Greater Minnesota Telehealth/e-Health Broadband Initiative (GMBTI)

FCC Rural Health Care Pilot

Quarterly Report

9/30/2010

1. Project Contact and Coordination Information

a. Identify the project leader(s) and respective business affiliations.

Project Leaders: Mark Schmidt, Project Coordinator, CIO
Jeff Plunkett, Associate Project Coordinator
Kap Wilkes, Associate Project Coordinator
SISU Medical Systems, Inc.
5 West 1st Street, Suite 200
Duluth, Minnesota 55802

b. Provide a complete address for postal delivery and the telephone, fax, and e-mail address for the responsible administrative official.

Mark Schmidt
SISU Medical Systems
5 West First Street, Suite 200
Duluth, MN 55802
Telephone: (218) 529-7900
Fax: (218)529-7920
mschmidt@sisunet.org

c. Identify the organization that is legally and financially responsible for the conduct of activities supported by the award.

SISU Medical Systems, Inc.

d. Explain how project is being coordinated throughout the state or region.

The Greater Minnesota Telehealth Broadband Initiative (GMTBI) Steering Committee is organized through a Memorandum of Agreement to act as an approving body for decisions and actions needed through the RFP/funding process as well as council to the Project Coordinator, Mark Schmidt, on behalf of the lead organization, SISU Medical Systems. The GMBTI Steering Committee meets in bi-weekly phone conferences for discussion and decisions and on an as needed basis to council on management of the project and make voting decisions during any competitive bidding procedures.

The voting members of the GMTBI Steering Committee members are:

1. Ron Brand, Minnesota Association of Community Mental Health Programs, representing over 120 mental health centers and satellites
2. Jon Linnell, North Region Health Alliance (NRHA), representing 19 hospitals in Minnesota and North Dakota (overlap with SISU, MTN)
3. Debra Ranallo, Medi-sota, Inc., non-profit consortium comprised of 30+ hospitals in Minnesota and South Dakota
4. Mark Schmidt, SISU Medical Systems, Inc., a non-profit consortium of 16 medical centers that share information technology resources (overlaps with MTN, NRHA, and Medi-sota, Inc.)
5. Currently vacant.

The non-voting regular participants of the GMTBI Steering Committee are:

1. Karen Welle, Minnesota Department of Health, Office of Rural Health and Primary Care
2. Mark Schoenbaum, Minnesota Department of Health, Office of Rural Health and Primary Care
3. Stuart Speedie, University of Minnesota, Center for Health Informatics, and Minnesota Telehealth Network
4. Zoi Hills, University of Minnesota, Center for Health Informatics Minnesota Telehealth Network
5. Myron Lowe, University of Minnesota, Information Technology
6. Jeff Plunkett, SISU Medical Systems
7. Kap Wilkes, SISU Medical Systems
8. Maureen Ideker, SISU Medical Systems

Temporary non-voting participants of the GMTBI Steering Committee include any active RFP's IT staff or administrators. All facilities that are involved in an active phase of the project are kept up to date of the project coordinator activity by being included in bi-weekly steering committee meetings. For our third phase of the project with more than 60 organizations considering participation within the network with more than 100 termination points, monthly project coordination phone conferences are scheduled.

2. Identify all health care facilities included in the network.

Addendum A: Spreadsheet of participating organizations includes those included in RFP00 and RFP01 and expected participants for RFP02.

a. Provide address (including county), zip code, Rural Urban Commuting Area (RUCA) code (including primary and secondary), six-digit census tract, and phone number for each health care facility participating in the network.

b. For each participating institution, indicate whether it is:

i. Public or non-public;

ii. Not-for-profit or for-profit;

iii. An eligible health care provider or ineligible health-care provider with an explanation of why the health care facility is eligible under section 254 of the 1996 Act and the Commission's rules or a description of the type of ineligible health care provider entity.

3. Network Narrative: In the first quarterly report following the completion of the competitive bidding process and the selection of vendors, the selected participant must submit an updated technical description of the communications network that it intends to implement, which takes into account the results its network design studies and negotiations with its vendors. This technical description should provide, where applicable:

a. Brief description of the backbone network of the dedicated health care network, *e.g.*, MPLS network, carrier-provided VPN, a SONET ring;

b. Explanation of how health care provider sites will connect to (or access) the network, including the access technologies/services and transmission speeds;

c. Explanation of how and where the network will connect to a national backbone such as NLR or Internet2;

d. Number of miles of fiber construction, and whether the fiber is buried or aerial;

e. Special systems or services for network management or maintenance (if applicable) and where such systems reside or are based.

The Network Diagram is available on the USAC GMTBI Sharepoint document library along with the RFP that describes the network. Additional network narrative will be developed over the coming quarters.

4. List of Connected Health Care Providers: Provide information below for all eligible and noneligible health care provider sites that, as of the close of the most recent reporting period, are connected to the network and operational.

a. Health care provider site;
b. Eligible provider (Yes/No);
c. Type of network connection (*e.g.*, fiber, copper, wireless);
d. How connection is provided (*e.g.*, carrier-provided service; self-constructed; leased facility);
e. Service and/or speed of connection (*e.g.*, DS1, DS3, DSL, OC3, Metro Ethernet (10 Mbps);
f. Gateway to NLR, Internet2, or the Public Internet (Yes/No);
g. Site Equipment (*e.g.*, router, switch, SONET ADM, WDM), including manufacturer name and model number.
h. Provide a logical diagram or map of the network.

Murray County Medical, Rice Memorial Hospital, and Sibley Medical Center, at the close of the most recent reporting period, are connected to the network. Johnson Memorial Hospital is not. The detail of each connection (a-e) is provided within the 466A package for RFP00, Network diagram, and contract documents. All of these documents have been uploaded and are available on the USAC RHCPP sharepoint site.

5. Identify the following non-recurring and recurring costs, where applicable shown both as budgeted and actually incurred for the applicable quarter and funding year to-date.

a. Network Design
b. Network Equipment, including engineering and installation
c. Infrastructure Deployment/Outside Plant
i. Engineering
ii. Construction
d. Internet2, NLR, or Public Internet Connection
e. Leased Facilities or Tariffed Services
f. Network Management, Maintenance, and Operation Costs (not captured elsewhere)
g. Other Non-Recurring and Recurring Costs

Budgeted information is currently available for RFP00 within the Network Diagram, Network Cost Worksheet, and 466A on the USAC GMTBI Sharepoint document Library. Actual costs correspond to the network cost worksheet and 466A.

6. Describe how costs have been apportioned and the sources of the funds to pay them:

a. Explain how costs are identified, allocated among, and apportioned to both eligible and ineligible network participants.

All participants are 100% eligible.

b. Describe the source of funds from:
i. Eligible Pilot Program network participants

Network participant's source of fund to cover costs is the individual organizations operational budget.

ii. Ineligible Pilot Program network participants

NA

c. Show contributions from all other sources (*e.g.*, local, state, and federal sources, and other grants). NA

i. Identify source of financial support and anticipated revenues that is paying for costs not covered by the fund and by Pilot Program participants.

NA

ii. Identify the respective amounts and remaining time for such assistance.

d. Explain how the selected participant's minimum 15 percent contribution is helping to achieve both the selected participant's identified goals and objectives and the overarching goals of the Pilot Program.

Not Applicable at this point in time.

7. Identify any technical or non-technical requirements or procedures necessary for ineligible entities to connect to the participant's network.

No ineligible entities are being considered for connecting to the participant's network during the pilot project.

8. Provide an update on the project management plan, detailing:

a. The project's current leadership and management structure and any changes to the management structure since the last data report; and

GMTBI Leadership and Management Structure (Details in paragraphn1-d)	
	September 2010 GMTBI Leadership and Mgmt Structure: no changes
	June 2010 GMTBI Leadership and Mgmt Structure: no changes
	March 2010 GMTBI Leadership and Mgmt Structure: no changes
	December 2009 GMBTI Leadership and Mgmt Structure: GMTBI Steering Committee is complete with a signed Memorandum of Agreement in place. The GMBTI Steering Committee meets regularly and will guide the project coordinator in the management of the project. There are 5 voting members within this committee; one from each participating network of HCPs. Additionally there are regularly contributing members from either state organizations or hospitals providing input and information. Mark Schmidt is acting as Project Coordinator, Jeff Plunkett and Kap Wilkes are acting as Associated Project Coordinators, SISU Medical Systems. Jeff Plunkett brings technical knowledge and skills that will support the RFP writing, vendor selection, and network implementation management. Kap Wilkes brings project management knowledge and will manage communication, documentation and reporting of the overall project and the invoicing process.. Karen Welle , of MN Dept of Health, Office of Rural Health and Primary Care, has been removed as Associate Project Coordinator, replace by Kap Wilkes, SISU Medical Systems.

b. In the first quarterly report, the selected applicant should provide a detailed project plan and schedule. ***The schedule must provide a list of key project deliverables or tasks, and their anticipated completion dates. Among the deliverables, participants must indicate the dates when each health care provider site is expected to be connected to the network and operational.*** **Subsequent quarterly reports should identify which project deliverables, scheduled for the previous quarter, were met, and which were not met. In the event a project deliverable is not achieved, or the work and deliverables deviate from the work plan, the selected participant must provide an explanation. 423 Non-recurring costs are flat charges incurred only once when acquiring a particular service or facility. Recurring usage or length of service contract.**

GMTBI Project Work Plan **Key project deliverables and timeline w/ explanation of delays or changes.**
In its project work plan, the GMTBI envisioned the creation of a strong integrated rural telehealth/e-Health infrastructure that will allow providers to exchange health care data and will ultimately allow any patient in any community in Minnesota to connect to any provider in Minnesota and beyond. Planning for achieving the goals set forth by the GMTBI is underway.
I. RFP00 : 4 HCP's + 1 Regional POP
September 2010 Update: 1. **Actual**: **a.** Invoicing process for the 4 HCP's and associated vendors started with July 2010 Submissions. This first submission included all of the months of the contract through April or May 2010. Submission included using the USAC invoice form, project coordinator signature, supporting documentation uploaded to the USAC sharepoint site and providing the vendor with the PC signed invoice. **b.** Additional submissions have been completed in September 2010 and October 2010. **c.** It is not known at the writing of this quarterly report how much, if any, USAC funds have been released to the participating vendors related to these 4 HCP's. **d.** It is not the responsibility of the project coordinators or HCP's to confirm that the vendors have received their 85% payment. However, it is our responsibility to provide accurate supporting documentation to USAC and submit invoices correctly and accurately to USAC and the vendor,

June 2010 Update:

1. **Actual**:
    a. written and approved by GMTBI Steering Committee, reviewed and posted by USAC for competitive bidding for 28 days: April-May 2009
    b. Competitive Bidding and Vendor selection: Mid-June 2009
    c. HCP/Telco Vendor contracts signed: June-July 2009
    d. HCP GMTBI Authorization for Payment and Certification of Eligibility form completed by participating HCPs and Assoc. Project Coordinator: May 2010
    e. 466A+Attachment and NCW submitted -May 2010
    i. There was significant delay between signed contracts and submitting the 466 package due to many factors that were significant as individual issues and proved to be complex in combination:
        1. Change in a vendor contract for the 'last mile' for 1 HCP.
        2. Back-order delay for switch/router equipment.
        3. Vendor 'miss-billing' of recurring monthly circuit costs took months to resolve.
        4. Vendor de-activating circuit due to lack of 100% payment took months to resolve.
        5. Vendor charging late fees and sending HCP account to collection agency due to lack of 100% payment took months to resolve.
        6. Delay in vendor response for Certification of Eligible Vendor.
        7. Lack of understanding of the USAC funding process by the project coordinators, steering committee, and USAC coach caused unexpected requirements and increased workload.
        8. Communication with Telco Vendors was slow and caused delays in problem solving.
        9. Lack of funding for project management and corresponding efforts to locate funding resources caused delays in funding process.
        10. Turn-over in the GMTBI leadership and management caused loss of knowledge and delay in funding process.
        11. Unknown requirement of Sustainability Plan including 10 year budget forecast added increased work load.

2. **Actual**: Funding Commitment Letter was issued by USAC on July 1, 2010
    a. The issuance of the FCL was delayed from May – June due to required revisions to the GMTBI Sustainability Plan. A 10year budget forecast was required along with extensive revisions in the narrative. The revised GMTBI Sustainability Plan ver 5.27.2010 was accepted by USAC in June 2010.
    b. 467 Form submitted and approved by USAC: July 2010
3. **Planned**:
    a. Successful first USAC invoicing completed for each Telco Vendor by July 31, 2010

March 2010 Update: GMTBI Project Coordinators continue to work directly with the USAC Coach to complete documentation of the 466A package and competitive bidding process. We are expecting approval and issuance of the Funding Commitment Letter no later than June 1, 2010. Assoc Project Coordinator is working with the four participating sites to create a reference document to be used by both the HCP's and Project Coordinator: Authorization for Payment and Certification of Eligibility. This document contains the same vendor, account, and cost information as the 466A and Network Cost Worksheet. We are expecting this information to be identically reflected within the Funding Commitment Letter.

December 2009 GMBTI work plan:
Complete documentation for RFP (00) and receive Funding Commitment Letter in order to begin invoice

reimbursement process with initial participants. This installation of the proposed circuits (and thus also the 466 documentation) was significantly delayed due to a last minute change in the last-mile service provider. This has now been rectified, the circuits installed and accompanying hardware installed.

II. RFP01 : Central Hub + 1 Regional POP + 3 HCPs

September 2010 Update:

1. **Actual**: 465 and 465-A approval and RFP approval for posting 28 day on September 23, 2010. This was a delay from planned early July 2010 of nearly a full 3 months.
   a. Final Approval of the 465 and 465-A had many edits for editing termination addresses and eligibility questions. Editing of the form to get the addresses correct, etc, was completed late August, 2010.
   b. Requirements of Community Mental Health questionnaires being completed for each termination location were identified in July 2010.
   c. Letter of Agency requirement to include all termination points. This was identified as needed when the two community mental health organizations had 5-9 termination points and their one organization LOA did not include the addresses/locations of those points. The LOA's were gathered and uploaded to USAC sharepoint August 2010.
   d. USAC review and verification of eligibility of the community mental health organizations began in August 2010. Two locations with the HDC organization were classified as ineligible in early September, 2010. On 9/8/2010 the GMTBI steering committee decided to reclassify these two sites as ineligible in order to not delay the RFP posting. The sites were ultimately removed from the 465 and 465-A prior to posting of the RFP.
   e. On 9/10/2010 the RFP was not posted and GMTBI project coordinators requested a status update. Another status update was requested on 9/13/2010. We were given feedback that the RFP would be posted within a day or two.
   f. 9/17/2010 GMTBI project coordinators were notified that a third site was identified by USAC as being ineligible. The GMTBI project coordinators and GMTBI Steering Committee chair agreed to reclassify that site as ineligible in accordance with the earlier decision regarding the first two ineligible sites in order to get the RFP posted as soon as possible.
   g. RFP01 posted for competitive bidding 9/23/2010 for 28 days.
2. **Planned**:
   a. Bids will be accepted through 10/22/2010..
   b. If a single bid is received on the hardware and MPLS programming, the project coordinators, after discussion with USAC , have decided to keep the RFP open for receiving bids for an additional 10 days.
   c. Competitive Bidding and Vendor selection: ~~Mid-September~~ Competitive bidding will not take place until **mid-late November**. A task force of IT / network experts will be formed by project coordinators to review and assess the bids. Recommendations will be made to the GMTBI steering committee in late November, 2010. Steering Committee members will vote on the bid selection. The bidding process and vendor selection is 2 months past expected dates due to delays in posting the proposal.
   d. 466A+Attachment and NCW submitted and approved: ~~October~~ **December 2010**
   e. HCPs Letters of Agency updated, HCP/Telco contracts signed: ~~October~~ **November 2010.**
   f. HCP-GMTBI Authorization for Payment and Certification of Eligibility form completed by participating HCPs and Assoc. Project Coordinator: **May 2010**
   g. Funding Commitment Letter issued by USAC ~~November~~ **January 2011**
   h. Implementation of Central Hub, POP, and HCP : September – ~~November~~ r **January 2011**
   i. Live Circuits ~~January~~ March 2011
   j. 467 Form submitted and approved by USAC: ~~January~~ **March 2011**
   k. Telco Vendor invoice process started : : ~~January~~ **March 2011**

June 2010 Update :

1. **Actual**: GMTBI Steering Committee approved the RFP on 6/10/2010. Delays in fine-tuning the RFP to incorporate network design details have taken several weeks to complete. USAC has been reviewing the RFP prior to posting as of 6/25/2010 with additional fine-tuning completed by assoc. project coordinator on 7/16/2010.
2. **Planned**: submitted for competitive bidding for 28 days July 2010
3. **Planned**:
   a. Competitive Bidding and Vendor selection: Mid-September
   b. 466A+Attachment and NCW submitted and approved: October
   c. HCPs Letters of Agency updated, HCP/Telco contracts signed: October
   d. HCP-GMTBI Authorization for Payment and Certification of Eligibility form completed by participating HCPs and Assoc. Project Coordinator: May 2010
   e. Funding Commitment Letter issued by USAC-November
   f. Implementation of Central Hub, POP, and HCP : September – November
   g. Live Circuits Jan 2011
   l. 467 Form submitted and approved by USAC: July 2010
   h. Telco Vendor invoice process started : Jan 2011

March 2010 GMTBI work plan: Project Coordinator and Associate Project Coordinator will complete a redesign of RFP01 to incorporate MLSP technology/programming. This redesign is needed due to changes in known technology since the initial GMTBI network planning. The RFP01 is expected to be completed, approved by the GMTBI Steering Committee, and submitted for bidding no later than June 1, 2010

Participating HCP's network connections are expected to be live and operational in Fall 2010.

December 2009 GMTBI work plan:
The RFP (01) has been submitted to USAC for review and will soon be posted for competitive bidding. This RFP , when completed will form the primary infrastructure for the entire project ; a centrally managed hub sites located in Crookston, Willmar, Minneapolis, and Duluth, MN

III. RFP02 : Network Build-out with 120+ HCPs

September 2010 Update:

1. **Actual**: Participating HCPs surveyed for updated connection needs: August, 2010. This update and survey of circuit needs has remained on schedule. The participating HCP's were provided with overview and FAQ information and a monthly IT planning project meeting has been taking place: September and October 2010.
2. **Planned**:
   a. RFP02 approved by GMTBI Steering Committee and reviewed by USAC by ~~mid-September~~ and posted for bidding for 60 days. This aspect of the work-plan has been revised to **December 2010**. The delay is a consequence of work to get the RFP01 posted and a vendor selected. Writing of the RFP02 is under process.
   b. 465 and 465-A approval **December 2010**
   c. Competitive Bidding and Vendor selection: ~~December~~ **March 2011**
   d. 466A+Attachment and NCW submitted and approved: ~~January~~ **April 2011**
   e. HCPs Letters of Agency updated, HCP/Telco contracts signed: ~~January~~ **April 2011**
   f. HCP-GMTBI Authorization for Payment and Certification of Eligibility form completed by participating HCPs and Assoc. Project Coordinator: ~~May~~ **June 2011**
   g. Funding Commitment Letter issued by USAC: ~~February~~ **June 2011**
   h. Implementation by region or vendor: ~~Jan – April~~ **June – August 2011**

i. Live Circuits and HCPs begin paying 15% : ~~April – May~~ **August – September 2011**
j. 467 Form submitted and approved by USAC: ~~July~~ **August-September 2011**
k. Telco Vendor Invoice process started: ~~May~~ **September – Oct 2011**

June Update:

1. **Actual**: Participating HCPs have been provided a GMTBI pilot project update
2. **Planned**: Participating HCPs will be re-surveyed for updated connection needs: August, 2010
3. **Planned**: RFP02 approved by GMTBI Steering Committee and reviewed by USAC by mid-September and posted for bidding for 60 days.
4. **Planned**:
   a. Competitive Bidding and Vendor selection: December 2010
   b. 466A+Attachment and NCW submitted and approved: January 2011
   c. HCPs Letters of Agency updated, HCP/Telco contracts signed: January 2011
   i. HCP-GMTBI Authorization for Payment and Certification of Eligibility form completed by participating HCPs and Assoc. Project Coordinator: May 2010
   d. Funding Commitment Letter issued by USAC: February 2011
   e. Implementation by region or vendor: Jan – April 2011
   f. Live Circuits and HCPs begin paying 15% : April – May2011
   g. 467 Form submitted and approved by USAC: July 2010
   h. Telco Vendor Invoice process started: May 2011

March 2010 GMTBI work plan: with RHCPP pilot extension to 6/30/2011 we continue to plan submission and implementation of RFP02. We expect to submit the RFP02 for competitive bidding in August 2010. The competitive bidding window will be 60 days due to the extensive size of the proposal.

Participating HCP's network connections are expected to be live and operational in Winter 2010 - Spring 2011.

December 2009 GMBTI work plan:

The RFP (02) is a large proposal, incorporating more than 120 facilities. ***We will not be able to complete this proposal, post for 60 days, and complete the 466 and NWC in time to receive a funding commitment letter prior to the 6/30/2010 filing deadline without significantly impacting the scope of our project***. However, if our request for a 1 year extension is approved we will be able to carefully and thoroughly submit this third RFP for all currently identified participants by mid-summer to be posted for 60 days and will expect implementation to be completed by the end of 2010.

IV. RHCPP Timeline Extension Request

March 2010 Update: The FCC ruled to extend the RHCPP deadline for all participating pilot projects to 6/39/2010. This extension will allow the GMTBI to successful implement RFP02.

December 2009 GMTBI work plan:

Seeking an extension of one year of the RHCPP filing deadline of 6/30/2010. This took the form of a written request to Thomas Buckley, FCC, from Greater Minnesota Telehealth Broadband Initiative (GMTBI) Project Coordinator asking to be considered along with other RHCPP projects that are requesting an extension. The FCC decision of an extension for all RHCPP projects is tied to the North Carolina Telehealth Network request, DA 09-2609.

9. Provide detail on whether network is or will become self sustaining. Selected participants should provide an explanation of how network is self sustaining.

Sustainability plan revised, ver 5.27.2010, included in this quarterly report as **Addendum B.**

10. Provide detail on how the supported network has advanced telemedicine benefits:

a. Explain how the supported network has achieved the goals and objectives outlined in selected participant's Pilot Program application;

b. Explain how the supported network has brought the benefits of innovative telehealth and,

in particular, telemedicine services to those areas of the country where the need for those benefits is most acute;

c. Explain how the supported network has allowed patients access to critically needed medical specialists in a variety of practices without leaving their homes or communities;

d. Explain how the supported network has allowed health care providers access to government research institutions, and/or academic, public, and private health care institutions that are repositories of medical expertise and information;

e. Explain how the supported network has allowed health care professional to monitor critically ill patients at multiple locations around the clock, provide access to advanced applications in continuing education and research, and/or enhanced the health care community's ability to provide a rapid and coordinated response in the event of a national crisis.

Not Applicable at this point in time.

11. Provide detail on how the supported network has complied with HHS health IT initiatives:

a. Explain how the supported network has used health IT systems and products that meet interoperability standards recognized by the HHS Secretary;

b. Explain how the supported network has used health IT products certified by the Certification Commission for Healthcare Information Technology;

c. Explain how the supported network has supported the Nationwide Health Information Network (NHIN) architecture by coordinating activities with organizations performing NHIN trial implementations;

d. Explain how the supported network has used resources available at HHS's Agency for Healthcare Research and Quality (AHRQ) National Resource Center for Health Information Technology;

e. Explain how the selected participant has educated themselves concerning the Pandemic and All Hazards Preparedness Act and coordinated with the HHS Assistant Secretary for Public Response as a resource for telehealth inventory and for the implementation of other preparedness and response initiatives; and

f. Explain how the supported network has used resources available through HHS's Centers for Disease Control and Prevention (CDC) Public Health Information Network (PHIN) to facilitate interoperability with public health and emergency organizations.

Not Applicable at this point in time.

12. Explain how the selected participants coordinated in the use of their health care networks with the Department of Health and Human Services (HHS) and, in particular, with its Centers for Disease Control and Prevention (CDC) in instances of national, regional, or local public health emergencies (*e.g.*, pandemics, bioterrorism). In such instances, where feasible, explain how selected participants provided access to their supported networks to HHS, including CDC, and other public health officials.

Not Applicable at this point in time.

Addendum A: GMTBI Participant Listing as of 6/30/2010, added contact information 10/30/2010.

HCP Name	Address	City	St	Zip	County	RUCA	Public or NFP	Eligibility	Census Tract
Altru Health Systems	1200 S. Columbia Rd	Grand Forks	ND	58201	Grand Forks	1	x	100%	
Appleton Area Health Services		Appleton	MN	56208	Swift	7	x	100%	
Bigfork Valley Hospital & Clinics	258 Pine Tree Drive	Bigfork	MN	56628	Itasca	10.6	x	100%	
Bridges Medical Center	201 9th St. W.	Ada	MN	56510	Norman	10.4	x	100%	9,603
Cavalier County Memorial Hospital	909 2nd St.	Landgon	ND	58429	Cavelier	10	x	100%	9,509
Children's Mental Health Services	35382 US Hwy 2 West	Grand Rapids	MN	55774				100%	
Clearwater Health Services	203 4th St. NW	Bagley	MN	56621	Clearwater	10.5	x	100%	1
Cloquet Community Memorial Hospital	512 Skyline Blvd	Cloquet	MN	55720	Carlton	4	x	100%	
Cook County North Shore Hospital & Care Center	P.O Box 10	Grand Marais	MN	55604	Cook	10	x	100%	
Cook Hospital	10 Fifth Street SE	Cook	MN	55723	St. Louis	6	x	100%	
Cooperstown Medical Center	1200 Roberts Ave. NE	Cooperstown	ND	58425	Griggs	10	x	100%	9,685
Cuyuna Regional Medical Center	320 East Main Street	Crosby	MN	56441	Crow Wink	7.4	x	100%	
Deer River HealthCare Center	1002 Comstock Drive	Deer River	MN	56636	Itasca	10	x	100%	

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HCP Name	Address	City	St	Zip	County	RUCA	Public or NFP	Eligibility	Census Tract
Ely-Bloomenson Community Hospital	328 West Conan Street	Ely	MN	55731	St. Louis	7.3	x	100%	
Fairview Health Services	2450 Riverside Ave.	Minneapolis	MN	55454	Hennepin		x	100%	
Family Life Center	1930 Coon Rapids Blvd.	Coon Rapids	MN	55433			x	100%	
First Care Health Center	115 Vivian St., PO Box 1	Park River	ND	58270	Walsh	10.6	x	100%	9,582
First Care Medical Services	900 Hilligoss Blvd. SE	Fosston	MN	56542	Polk	10	x	100%	210
Fraser Child and Family Center	2400 W. 64th St	Minneapolis	MN	55423	Hennepin		x	100%	
Glencoe Regional Health Services	1805 Hennepin Ave. N	Glencoe	MN	55336	McLeod		x	100%	
Graceville Health Center	115 W. 2nd St., PO Box 157	Graceville	MN	56420	Big Stone	10	x	100%	
Grand Itasca Clinic and Hospital	1601 Golf Course Rd	Grand Rapids	MN	55744	Itasca		x	100%	
Granite Falls Municipal Hospital	345 10th Ave	Granite Falls	MN	56421	Yellow Medicine	7	x	100%	
Human Development Center	1401 E. 1st St.	Duluth	MN	55085	St. Louis	1	x	100%	
Human Services, Inc	7066 Stillwater Blvd. N.	Oakdale	MN	55128		1	x	100%	
Hutchinson Area Health Care	1095 Highway 15 South	Hutchinson	MN	55350	McCleod	4	x	100%	
Johnson Memorial Health Services	1282 Walnut Street	Dawson	MN	56232	Lac Qui Parle	10.6	x	100%	

HCP Name	Address	City	St	Zip	County	RUCA	Public or NFP	Eligibility	Census Tract
Kanabec Hospital	301 South Hwy 65	Mora	MN	55051	Kanabec	8.3	x	100%	
Kittson Memorial Healthcare Center	1010 S. Birch, PO Box 700	Hallock	MN	56728	Kittson	10	x	100%	9,902
Lakeland Mental Health Center	126 E. Alcott Ave.	Fergus Falls	MN	56537		4	x	100%	
LakeWood Health Center	600 Main Ave. S.	Baudette	MN	56623	Lake of the Woods	10	x	100%	9,603
Madison Lutheran Home	900 2nd Ave.	Madison	MN	56256	Lac Qui Parle	10	x	100%	
Mercy Hospital & Healthcare Center	710 South Kenwood Ave	Moose Lake	MN	55767	Carlton	10.5	x	100%	
Murray County Medical Center	2042 Juniper Avenue	Slayton	MN	56172	Murray	10	x	100%	
Nelson County Health System Hospital & Clinic	200 N. Main St.	McVille	ND	58254	Nelson	10	x	100%	9,588
North Valley Health Center	109 S. Minnesota St.	Warren	MN	56762	Marshall	10.4	x	100%	9,804
Northern Pines Mental Health Center, Inc.	1906 5th Ave. SE	Little Falls	MN	56345		7.3	x	100%	
Northwestern Mental Health Center	603 Bruce St.	Crookston	MN	56716		8	x	100%	
Northwood Deaconess Health	4 N. Park St., PO Box 190	Northwood	ND	58267	Grand Forks	10.4	x	100%	118
Pembina County Memorial Hospital	301 Mountain St. E., PO Box 380	Cavelier	ND	58220	Pembina	10	x	100%	9,503

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HCP Name	Address	City	St	Zip	County	RUCA	Public or NFP	Eligibility	Census Tract
People Incorporated Mental Health Services	317 York Ave.	St. Paul	MN	55130		1	x	100%	
Pine Medical Center	109 Court Ave. S.	Sandstone	MN	55072	Pine	2	x	100%	
Range Mental Health Center, Inc.	624 S. 13th St.	Virginia	MN	55792			x	100%	
Redwood Area Hospital	100 Fallwood Rd.	Redwood Falls	MN	56283	Redwood	7	x	100%	
Regina Medical Center	1175 Nininger Road	Hastings	MN	55033	Dakota	4.1	x	100%	
Renville County Hospital & Clinics	611 E. Fairview Ave.	Olivia	MN	56277	Renville	10	x	100%	
Rice Memorial Hospital	301 Becker Ave SW	Willmar	MN		Kandiyohi	4	x	100%	
River's Edge Hospital	1900 N. Sunrise Dr.	St. Peter	MN	56082	Nicollet		x	100%	
Riverview Healthcare Association	323 S. Minnesota St.	Crookston	MN	56716	Polk	7	x	100%	207
Riverwood Healthcare Center	200 Bunker Hill Drive	Aitkin	MN	56431	Aitkin	10	x	100%	
Sibley Medical Center	601 W. Chandler Street	Arlington	MN	55307	Aitkin	10	x	100%	
SISU Medical Systems	5 W. 1st St., Suite 200	Duluth	MN	55802	Sibley	7	x	100%	
Sleepy Eye Medical Center	400 4th Ave. NW, PO Box 323	Sleepy Eye	MN	56085	St. Louis		x	100%	
St. Mary's Innovis Health	1027 Washington Avenue	Detroit Lakes	MN	56501	Becker	7	x	100%	
St. Michael's Hospital	425 Elm St. N	St. Michael	MN	56378			x	100%	

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HCP Name	Address	City	St	Zip	County	RUCA	Public or NFP	Eligibility	Census Tract
Swift County-Benson Hospital	1815 Wisconsin Avenue	Benson	MN	56215	Swift	x		100%	
Tri-County Hospital	415 Jefferson St. N.	Wadena	MN	56482	Brown	7.4	x	100%	
Union Hospital	42 6th Ave. SE	Mayville	ND	58257		7	x	100%	
Unity Medical Center	164 W. 13th St.	Grafton	ND	58237	Trail	10	x	100%	9,702
Western Mental Health Center	1212 E. College Dr.	Marshall	MN	56258	Walsh	7	x	100%	9,580

Addendum B: Sustainability Plan ver 5.27.2010– narrative and budget forecast

Greater Minnesota Telehealth/e-Health Broadband Initiative (GMBTI)

FCC Rural Health Care Pilot

SUSTAINABILITY PLAN

May 2010

GREATER MINNESOTA TELEHEALTH/E-HEALTH BROADBAND INITIATIVE

The Greater Minnesota Telehealth/e-Health Broadband Initiative (GMTBI) is an affiliation of several existing health care networks in Minnesota representing over 120 health care facilities that came together in 2007 to apply for funding under the FCC Rural Health Care Pilot. The partner networks include: Medi-Sota Inc, MN Telehealth Network, MN Association of Community Mental Health Program, North Region Health Alliance, and SISU Medical Solutions. Supporting organizations include the Minnesota Department of Health and the University of Minnesota.

LONGTERM GOALS OF GMTBI

- Interconnect the pilot sites identified in its 2007 application.
- Create a robust, reliable and secure network for regional and statewide health information exchange and telehealth, including but not limited to rural and urban hospitals, physician clinics, community clinics, community mental health centers, local and county public health and social service agencies, home health care agencies, long term care facilities, correctional facilities, tribal health facilities, K-12 and higher education, and patients' homes.
- Integrate established telecommunication networks serving various healthcare systems into a seamless broadband enabled telehealth and telemedicine delivery service infrastructure dedicated to improving access to health care across rural Minnesota and beyond.
- Promote technical standards and operational best practices to reduce costs, boost performance, and improve user-friendliness of telehealth application.

The GMTBI network plan builds upon existing network relationships, allowing participating facilities to interconnect with:

- Rural health care facilities within their region and in urban areas.
- The University of Minnesota Network and Minnesota State Colleges and Universities network including the regional higher education distance learning networks.
- MNET, the state network servicing all state, county, and city services and education.
- Other state health care system provider IP networks, i.e. Mayo, Allina, Fairview, etc.
- Neighboring state health care networks, i.e. Avera Telehealth and Iowa HealthNet Connect Internet2 and National Lambda Rail (national backbones).

Pilot GOVERNANCE: GMTBI STEERING COMMITTEE

The five Partner organizations have established through a Memorandum of Agreement a governing steering committee to ensure that development of the telehealth broadband network meets statewide goals.

The GMBTI Partner Networks and Steering Committee members have agreed to:

1) Represent the partner networks and its member facilities with 1 voting privilege per partner network for decisions and actions as required during the life of the pilot
2) Provide strategic direction and counsel to the Project Coordinator on the development and implementation of the network related to meeting the Partner organization's needs, GMTBI goals and objectives, and FCC rules
3) Develop and/or approve a project plan, including timelines and projected budget, for the Pilot.
4) Develop communications strategies, information pieces and marketing tools to assist potential sites in participating in the Pilot.
5) Conduct quarterly meetings, monthly conference calls and ad hoc discussions
6) Disseminate information to participating facilities
7) Maintain a GMTBI share point website to keep all steering committee members and participating Health Care Provider facilities informed of planning, progress and communications
8) Participate in the Request for Proposal (RFP) process, including thorough review and approval of RFPs and network plan(s) prior to submission, review of vendor bids and selection of vendor(s), and invoice reimbursement process.
9) Non-voting participation on the Steering Committee is open to supporting organizations and participating healthcare organization.

Pilot MANAGEMENT AND COORDINATION: Lead Organization

The GMTBI Steering Committee voted to have SISU Medical Systems, Inc. act as Project Lead Organization on their behalf in implementing the project. Mark Schmidt, SISU CIO, is the FCC's named Project Coordinator on behalf of SISU; Jeff Plunkett and Kap Wilkes are the associate project coordinators on behalf of SISU. The Project Coordinator assigns associate

project coordinators as needed to assist in the project management and technical implementation of the RHCPP on behalf of GMTBI.

SISU Medical Systems has the technical knowledge and expertise to develop and design the network plan and the organizational capacity to coordinate the USAC funding process. It is an IT organization supporting a consortium of 16 rural healthcare facilities. SISU has a 10-year proven and successful track record of managed collaboration and existing technical infrastructure in a position to contribute on a state level, thus strengthening the long-term sustainability of the project.

The Lead Organization and Project Coordinator, SISU Medical Systems, has agreed under direction and approval from the GMTBI Steering Committee to:

1) Act on behalf of the GMTBI before the Federal Communications Commission (FCC) in matters related to the Rural Health Care Pilot Program (Pilot), submit all forms, attachments, and reports necessary to the FCC and/or the USAC Rural Health Care Division.
2) Appoint staff to act as project manager(s) to support their lead organization role for the Pilot in a manner consistent of the long term vision and goals of the GMTBI Steering Committee and in accordance with FCC rules.
3) Work with GMTBI Steering Committee representatives and participating sites to identify needs, develop requests for proposal for telecommunications services, review and select vendors
4) Complete and implement a network plan that meets GMTBI goals and objectives
5) Provide technical assistance to sites to advise on installation of selected hardware and services as appropriate, but not bid on or provide any of the services that require bidding, including installation.
6) Continue to follow any applicable federal, state or local procurement rules and retain all documentation of activities related to the Pilot Program for five years from the end of the last funding year.

PHASED APPROACH TO IMPLEMENT GMTBI FCC PILOT

A phased approach to implement the project was adopted in order to meet priority needs, build organizational capacity and processes, and complete the 3-5 year plan.

- **Phase I Objective:** Immediately meet the needs of eight participating facilities that lacked any level of broadband and build the organizational capacity required to manage the project, while building individual facility participation through outreach and education.
- **Phase II Objective:** Build a centrally managed hub and regional nodes capable of supporting addition of remaining sites to the network in Phase III.
- **Phase III Objective:** Add all remaining sites identified in the FCC application.

In addition to meeting immediate and long-term needs, the phased approach:

- Builds organizational and administrative capacity of SISU Medical Systems required to manage the project, including processes for submission of USAC forms, selection of vendors, and quarterly reporting during the duration of the project.
- Builds individual facility participation through marketing, outreach and education by GMTBI Steering Committee members and SISU Medical Systems.
- Contributes to long-term sustainability of the network by ensuring that facility participation in the network provides value by building upon existing health care business relationships and referral patterns, and providing needed connections for health information exchange, meaningful use of electronic health records, and telehealth services.

GMTBI Network Design

The GMTBI network will provide broadband connectivity to all participating HCP through 2 regional nodes and 1 central hub. This design allows local sites in the network to share health information or Telehealth services with other healthcare locations in Minnesota and western North Dakota, and ultimately, with other health care providers regionally and nationally. We are currently designing Phase II of our network to incorporate MPLS technology and programming. A complete written description and network diagram will be included in the next quarterly report, June, 2010.

Summary Financial Plan

For the initial pilot build-out of our GMTBI network there will be a combination of onetime equipment/infrastructure costs and recurring connectivity costs. This summary financial budget has been created based on the FCC Pilot application and updated with infrastructure Equipment/infrastructure 1-time cost estimates for the 2 regional nodes and central hub hardware, as of May, 2010.

GMTBI Summary Forecast 10 Yr Budget of GMTBI Network

		RHC Pilot Project 15% hardware + circuit costs)					RHC Primary Mechanism (50% circuit costs)					
		2009	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**GMTBI TOTAL**
Estimated costs :												
Network Infrastructure: Nodes & Hub												
	Equipment Cost (2)	$24,900	$99,600									$124,500
	Annual Circuit cost (3)		$6,705	$26,820	$26,820	$26,820	$89,400	$89,400	$89,400	$89,400	$89,400	$534,165
HCP Circuits												
	Equipment Cost (4)	$4,500	$137,400									$141,900
	Annual Circuit cost (5)		$16,200	$162,000	$162,000	$162,000	$540,000	$540,000	$540,000	$540,000	$540,000	$3,202,200
Estimated Network Hardware and Circuit COSTS		**$29,400**	**$259,905**	**$188,820**	**$188,820**	**$188,820**	**$629,400**	**$629,400**	**$629,400**	**$629,400**	**$629,400**	**$4,002,765**

	Pilot Project Coordination (6)	$45,000	$67,500									$112,500
	On-Going Network Support (7)			$81,000	$82,620	$84,272	$85,958	$87,677	$89,431	$91,219	$93,044	$695,220
	On-Going Network Administration (7)			$30,375	$30,983	$31,602	$32,234	$32,879	$33,536	$34,207	$34,891	
	Estimated Network Management Cost	**$45,000**	**$67,500**	**$111,375**	**$113,603**	**$115,875**	**$118,192**	**$120,556**	**$122,967**	**$125,426**	**$127,935**	**$807,720**
TOTAL COSTS		**$74,400**	**$327,405**	**$300,195**	**$302,423**	**$304,695**	**$747,592**	**$749,956**	**$752,367**	**$754,826**	**$757,335**	**$4,810,485**

		RHC Pilot Project 15% hardware + circuit costs)					RHC Primary Mechanism (50% circuit costs)					
		2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	GMTBI TOTAL
Estimated Income												
	HCP 15% Match during Pilot	$29,400	$259,905	$188,820	$188,820	$188,820						$855,765
	HCP circuit costs estimated through Primary USAC funding mechanism (10)						$629,400	$629,400	$629,400	$629,400	$629,400	$3,147,000
	HCP LOA Admin Fee (8)	$24,375	$8,125									$32,500
	MN Dept of Health Grant	$41,250	$41,250									$82,500
	HCP Network Management Cost Sharing (9)	-$20,625	$18,125	$111,375	$113,603	$115,875	$118,192	$120,556	$122,967	$125,426	$127,935	$692,720
TOTAL INCOME		**$74,400**	**$327,405**	**$300,195**	**$302,423**	**$304,695**	**$747,592**	**$749,956**	**$752,367**	**$754,826**	**$757,335**	**$4,810,485**

Assumptions and Definitions:

1	The costs in this spreadsheet include only the 15% that the GMTBI HCP's , nodes, and hubs incur
2	RFP00 includes equipment costs for one node and three HCP's in late 2009, the remaining nodes and central hub are included in RFP01 which is planned for Fall 2010
3	RFP01 is planned to have active circuits in Fall 2010
4	3 HCPs had equipment installed in Fall-Winter 2009 through RFP00
5	Approximately 10% of circuits were activated in 2010 through RFP00

6	Project Coordination includes network design, RFP writing, project management, quarterly reports, sustainability plan writing, HCP communication, steering committee
7	On-going network support assumes 1 FTE for support for hardware, router programming, changes, and .75 FTE for network administration assistance with the USAC invoicing mechanisms. These payroll costs include a 2% annual increase
8	HCP LOA administrative fee includes $500 per HCP organization that signed a LOA. It is for pilot administration and project coordination
9	HCP Network Management Cost Sharing is a concept where all participating HCP organizations that sign a LOA and participate on the GMTBI network also participate in sharing the cost of ongoing network management. This has not been needed during the first two years of the pilot because of the LOA Admin Fee and the MDH grant.
10	It is not known at the time of creating this spreadsheet what the HCP circuit costs will be after the transition from the pilot to the Primary USAC mechanism. However, the responsibility of the operational expense of the GMTBI circuits is assumed to be beneficial for participating HCP and expected to take place.

Administrative support of the RHCPP invoicing process: The administrative cost in terms of human resources has been a burden to the Project Coordinator organization, SISU Medical Systems. Some costs have been offset by two sources, State of Minnesota Office of Rural Health and Primary Care, grant for 2009- 2010, $85,000 and HCP $500 participation fee, as of May, 2010 . But considerable time has been volunteered. Likewise GMTBI Steering Committee members and participating HCP IT Staff have also been volunteering their time to participate in the pilot. The Steering Committee will continue to work toward identifying ways to sustain the GMTNI beyond the Pilot Project. Following are some of ideas that have been discussed.

Sustainability beyond Pilot Project

- Looking beyond the pilot, each participating HCP has budgeted for return to the subsidy provided under the Primary USAC program.
- Reimbursements for telehealth services by Minnesota health plans, Medicare, and Medicaid, are continuing to improve and help facilities in recovering costs for telecommunications and telehealth equipment and associated costs.
- Minnesota's Critical Access Hospitals, which make up a significant number of facilities in the GMTBI, will continue participate in the Medicare Rural Hospital Flexibility Program cost-based reimbursement and cost-reporting, including the match required under the primary USAC subsidy.
- Current Minnesota law requires all health care providers to utilize e-prescribing for all prescriptions by 2011 and have interoperable electronic health records by 2015.
- The Medicare and Medicaid HITECH Act incentives will contribute an important source of recovery for achieving interoperability for health information exchange and eCare/telehealth for Minnesota providers, including those participating in the GMTBI and those brought into the network in the future. Imposed penalties beginning in 2016 are motivating all of Minnesota's providers to resolve their connectivity and interoperability issues by said date.
- Realized savings to participating HCPs from reduced drive time, health care provider and physician time, will offer value to facilities for telehealth and eCare application.
- Identification of additional funding opportunities to support e-Health applications and collaborations are available through HRSA's Office of Rural Health Policy, Office of Advancement for Telehealth, USDA Rural Development, Minnesota's Rural Hospital Flexibility Program sub-grants, and foundation funding, such as the Helmsley Trust and Robert Wood Johnson Foundation.
- Continuation of the GMTBI Steering Committee or similar statewide coordinating board will ensure support for continued growth of the network and support access to grant opportunities listed above.
- Continuation of support from the Minnesota Department of Health, the University of Minnesota, the Minnesota Telehealth Registry, and the Great Plains Telehealth Resource Center will ensure that the GMTBI network continues to coordinate with other state and regional efforts.
- Plans for continued marketing and outreach efforts to expand network membership to facilities not currently included in the pilot will create additional support for long-term sustainability.